KBMIRT-100
Rev. 4/14

Kentucky Board of Medical Imaging & Radiation Therapy

42 Fountain Place
Frankfort, KY 40601

Instructions

Print in ink or type.

Answer each item completely and accurately. Incomplete answers may result in delay of your license.

LICENSE APPLICATION FORM

FOR DEPT. USE ONLY
DO NOT WRITE IN THIS SPACE

_____

_____

I. PERSONAL INFORMATION

Date of Birth: _____
Month Day Year

Social Security Number: ☐☐☐ ☐☐ ☐☐☐☐

_____
Home or Cell Phone Number

NAME: _____
(Last) (First) (Middle)

MAILING ADDRESS: _____
(Street, Road, or Box No.)

_____
(City) (State) (Zip Code)

EMAIL ADDRESS: _____

II. GENERAL

A. Fees: Application applying for and fees associated with application.

1. Medical Imaging or Radiation Therapy License
   - ☐ Radiography (Graduate of JRCERT Accredited Program & ARRT Registered)..... $60.00
   - ☐ Nuclear Medicine (Graduate of JRCNMT Accredited Program & ARRT or NMTCB Registered)..... $60.00
   - ☐ Radiation Therapist (Graduate of JRCERT Accredited Program & ARRT Registered)..... $60.00
   - ☐ Radiologist Assistant (Graduate of JRCERT Accredited Program & ARRT Registered)..... $60.00
2. Limited License
   - ☐ LXMO (Kentucky) $60.00
   - ☐ Podiatry (Kentucky)..... $60.00
   - ☐ Bone Densitometry (Kentucky) $60.00
3. Temporary License **(Valid for one year-Not renewable)**
   - ☐ Graduate of a JRCERT or JRCNMT Accredited Program..... $50.00
   - ☐ Graduate of Limited Radiography Program..... $50.00
   - ☐ Graduate of the Kentucky Independent Limited Program $50.00
4. Provisional License **(Valid for one year-renewable)**
   - ☐ Nuclear Medicine Alternate Course of Study $50.00

   Must provide documentation of progress to renew

MAKE CHECK OR MONEY ORDER PAYABLE TO: THE KENTUCKY STATE TREASURER

B. Have you previously applied for Kentucky Medical Imaging or Radiation Therapy License?
(Check appropriate box) ☐ yes ☐ no

If "Yes", When _____

III. EMPLOYMENT INFORMATION

_____
Work Telephone Number

A. Place of Employment (Name): _____

B. Business Address: _____
(Street, Road, or Box No.)

_____
(City) (State) (Zip Code)

C. Where are you employed? (Check appropriate box)

- ❑ Hospital
- ❑ Clinic
- ❑ Private Office
- ❑ Unemployed
- ❑ Mobile Health Service
- ❑ Other _____

D. Are any radiographic examinations, utilizing contrast media (e.g. gall bladder, GI series, IVP, etc.) performed at your place of employment? ❑ yes ❑ no

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IV. PROFESSIONAL CERTIFICATION/REGISTRY

A. Are you certified by The American Registry of Radiologic Technologist (ARRT)?
(Check appropriate box) ❑ yes ❑ no

B. If "Yes", submit a copy of the **ARRT registry certificate**.

C. Are you certified by the Nuclear Medicine Technology Certification Board (NMTCB)?
(Check appropriate box) ❑ yes ❑ no

D. If "Yes", submit a copy of the **NMTCB certificate**.

E. Please list all post-primary certifications that you currently hold, and submit appropriate documentation for each.

_____

V. EDUCATION INFORMATION

A. Have you graduated from High School? (Check appropriate box) ❑ yes ❑ no
If "Yes", year of graduation _____

B. Have you passed a High School Equivalency Test (GED)?
(Check appropriate box) ❑ yes ❑ no

If "Yes", give Equivalency Certificate Number: _____ Date: _____

C. Indicate the type of teaching facility where you received your training.
(Check appropriate box)

- ❑ Hospital
- ❑ Vocation/Technical School
- ❑ Junior/Community College
- ❑ University
- ❑ Military
- ❑ Kentucky Limited Independent Study Course
- ❑ Other _____

D. Name and address of the teaching facility at which you received your medical imaging or radiation therapy training:
Name and address of teaching facility: _____

_____

Date of Graduation: _____

Did you graduate from a JRCERT or JRCNMT accredited program? _____

E. Have you received a degree from a college/university? (Check appropriate box) ❑ yes ❑ no

If "Yes", check the appropriate box for the highest degree received:

❑ AA/AS ❑ BA/BS ❑ MA/MS ❑ Ph.D. ❑

VI. SIGNATURE/DATE

All applicants please read and sign/date the statement below. All applications will be null and void unless properly signed and dated.

I hereby submit this application and supporting documents and attest to the authenticity and accuracy of the application and all information contained herein. I further understand that if any information contained in this application or supporting documents submitted on my behalf, is determined to be false or misleading, this may be cause for denial, revocation or suspension of any license pursuant to this application and for criminal prosecution and punishment.

_____ _____

(Signature of Applicant) (Date)

MAIL APPLICATION FORM AND APPROPRIATE FEE TO:

Board of Medical Imaging & Radiation Therapy
42 Fountain Place
Frankfort KY 40601

APPLICATIONS WILL BE PROCESSED WITHIN 2-4 WEEKS FROM RECEIPT OF APPLICATION IN THIS OFFICE.

Please keep us informed, in writing, of any address or name changes that may occur in the future so your license renewal packet will be mailed to the correct address.